

# Placer County Department of Health and Human Services

## Intranasal (Live) or Injectable (Inactivated) H1N1 Influenza Vaccination Screening and Consent Form

For your child to be eligible to receive H1N1 influenza vaccine at the school clinic, **you must read, answer all questions, and sign this consent form.** Please read both the 2009 H1N1 Live, Attenuated (nasal spray) and Inactivated ("flu" shot) Vaccine Information Statements. Students age 9 years and younger will require a second dose of either type vaccine about a month after the first. This consent form will cover both flu vaccine doses, if needed.

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: Male or Female  
 (First) (Last) (mm-dd-yyyy)  
 PHONE: ( ) \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 NAME OF SCHOOL \_\_\_\_\_ TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_

Please circle Yes or No for the following questions **and** answer **ALL** questions.

1) Is your child allergic to eggs, egg proteins, gentamicin, gelatin, or arginine?	Yes	No
2) Does your child have any severe (life-threatening) allergies?	Yes	No
3) Has your child ever had a serious allergic reaction to the Influenza (Flu) Vaccine or to any other type of vaccine? If yes, please explain: _____	Yes	No
4) Has your child received Nasal Seasonal Flu (FluMist), MMR, and/or Varicella (chickenpox) vaccine in the past 4 weeks? Vaccine _____ Date _____	Yes	No
5) Does your child take long term aspirin therapy or aspirin-containing therapy?	Yes	No
6) Does your child have any long term medical conditions such as heart disease, diabetes or kidney disease? If yes, please explain): _____	Yes	No
7) Does your child have asthma?	Yes	No
8) Has your child ever had Guillain-Barré syndrome?	Yes	No
9) Is your child pregnant or could she become pregnant within the next month? (If applicable)	Yes	No
10) Does your child have a weakened immune system caused by cancer, cancer treatments, and other diseases or take a medication such as steroids that weaken the immune system?	Yes	No
11) Is your child in close contact with a person with a severely weakened immune system?	Yes	No
12) Have you been told by your child's doctor that he/she should not receive the flu vaccine?	Yes	No

I have read (or had explained to me) and understand and agree with the information provided to me in the Vaccine Information Statements for the **Live, Intranasal H1N1 Influenza Vaccine and the Inactivated, Injectable H1N1 Influenza Vaccine** (Vaccine Information Statement, 10/02/09). I understand that, based on vaccine availability and the responses to the questions above, my child may receive either the injectable or the intranasal flu vaccine at his/her school. I request and voluntarily give my permission for my child whose name is listed above, of whom I am the parent or legal guardian to receive the influenza (flu) vaccine.

**Parent/Legal Guardian Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

FOR CLINIC USE ONLY						
Date:	Dose:	Vaccine / Mfg	Lot # / Exp. Date	IZ Given By: MD/RN/LVN	Site/Route:	
	#1				IM RD IM LD Nasal	
	#2				IM RD IM LD Nasal	

(For information on Placer County Privacy Practices [HIPAA 45CFR 164.520-164.528], call 530-889-7141.)